Patient Benefits Questionnaire

The Texas Chiropractic Association (TCA) and the American Chiropractic Association (ACA) have taken note of certain practices used by managed care networks that are contracted with some insurers such as United Healthcare, Aetna, Oxford Health Plans, Cigna, etc. The TCA and ACA are bringing practices such as those listed below to the attention of state and federal regulators so that chiropractic patients can obtain the care delineated in their plan of health coverage.

If you are willing to assist in this effort to help all chiropractic patients, please simply:

1. Answer the questions below – if they reflect how you feel, simply place a check in the box by the statement.
2. Sign the HIPAA Authorization so that the TCA/ACA may have your permission to share your thoughts and or your medical chart with regulators.
3. Fill in your name, phone number and best time to call in the event that a regulator should wish to ask you questions about the concerns you have. Even if you would not like to be contacted by a state regulator, your answers to the questions below are helpful to this effort.
4. Fax a copy of this document and a copy of the patient's insurance card to the Texas Department of Insurance at: 512-475-1771

Patient Concerns:

☐ I feel that the paperwork that I am required ***by my insurer*** to fill out at my provider's office is burdensome. I feel my doctor does an adequate job of documenting my medical progress without the need for these forms.

☐ I feel that the paperwork that I fill out for my managed care network does NOT adequately illustrate or explain my condition in a manner sufficient to allow the network staff to make a decision regarding the care I need. That decision should be made solely by my doctor of chiropractic.

☐ I am concerned that the managed care network my insurer is using to manage my benefits sometimes limits the care I can receive to a level below what I need.

☐ I feel that if my employer (or I) purchased chiropractic benefits, I should be able to use those benefits when my physical condition warrants care.

☐ To my knowledge, my insurer has not performed a Patient Satisfaction Survey in the past year.

My insurance company is _____.
(Name of Insurer)

The Managed Care Network used to manage my benefits is:

_____.
(Name of Managed Care Network)

☐ My complaint pertains to all dates of service that I have received care.

☐ My complaint pertains only to this/these dates of service: _____.

If regarding specific date(s) you visited your doctor, the amount of the charges were:

(Note: This question is solely asked for the purpose of assisting regulators in their inquiry into your concern. Your doctor can assist you with this information.)

Amount of charges (if applicable):_____

_____

Authorization to Release Protected Information (HIPAA):

I, _____ , give permission to
(Patient Name)
_____and any of its employees
(Name of Clinic or Doctor)
to disclose the following protected health information to the American Chiropractic Association, Inc.("ACA") and to regulatory agencies for the purpose of investigation into the appropriateness of the policies and practices used to manage my chiropractic benefits.

Information to be disclosed (check all that apply):

- ☐ All necessary medical, treatment, diagnostic, billing, and any other records related to my care.

  OR Only:
- ☐ Diagnostic Records
- ☐ This Questionnaire
- ☐ Treatment Records
- ☐ Other:_____

Purpose: This protected health information will be used by the American Chiropractic Association for the sole purpose of investigating the appropriateness of the management of your chiropractic insurance benefits. This information may be submitted to state and/or federal regulatory agencies for their investigation as well. There is a potential that the information may be utilized and re-disclosed by such agencies and no longer protected for reasons beyond our control.

Duration/Revocation: This authorization will remain in effect until such time as you revoke it or until December 31, 2010, whichever is earlier. Finally, you may revoke this authorization in writing at any time by sending written notification to your doctor's office or to the ACA. Your notice will not apply to actions taken by the requesting person/entity prior to the date they received your written request to revoke authorization.

Right to Refuse: You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

Right to obtain copy: You may inspect or obtain a copy of the protected health information to be used or disclosed under this authorization. Should you desire a copy of this information, please notify your doctor.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Participant or Personal Representative

_____
Description of Personal Representative's Authority and Relation to Patient

_____ _____
Witness Date

Contact Information:

☐ I am willing for a regulator who has questions about my concern to contact me.

Preferred method of contact:

☐ Email - Email address:_____

☐ Telephone - Telephone number:_____

Best time to call:_____